STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155724	A. BUILDING _____ B. WING _____	C 06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBRIDGE HEALTH CAMPUS	**602 WOODBRIDGE AVE LOGANSPORT, IN 46947**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint #IN00174190. Complaint #IN00174190- Substantiated. No deficiencies related to the allegations are cited. Survey dates: June 15 & 16, 2015 Facility number: 003691 Provider number: 155724 AIM number: 200456230 Census bed type: SNF- 39 SNF/NF- 20 Residential - 22 Total- 81 Census payor type: Medicare- 18 Medicaid- 21 Other- 20 Total- 59 Sample- 3 Woodbridge Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint #IN00174190.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE